#16. Q: The numbers the government quotes in Section B seem to be materially inflated from the present experience of Tricare For Life (TFL) Medical Claims, even if one adds the nominal amount of claims now being processed for Dual Eligible beneficiaries under age 65. Our best estimates of annualized TFL claim volume without the TRICARE Senior Pharmacy do not approach the volumes quoted in Section B. Could TMA please compare the total number of claims presented in Option Period 1 to the number of medical claims to date experienced nationally for dual eligible beneficiaries since the inception of the TFL program and give some logic for the increase shown? We believe it is important to understand why the government believes the claim volumes will be this high since a variation in volume this large could negatively affect transition costs and the amount of infrastructure required for the contract.

A: For the purposes of this requirements type solicitation, the estimated claims volumes figures in Section B were developed by annualizing the TFL claims from Spring 2002 and trending them forward to later years based on the estimated increases in the number of TFL eligibles and increased TFL utilization per eligible. Please refer to RFP Attachment L-4 for historical monthly claims volumes (October 2001 -through May 2002) for TFL under the current managed care contracts. Because the agency has chosen to use the above described methodology, the agency will not perform a comparison as suggested in Question 16.

#17. Q: What are the call incident rates for the Customer service requirements of this solicitation? The RFP provided claims volume, but there was no information on call volumes.

A: Response being prepared.

#18. Q: What is the requirement for sending EOB's to members? Will an EOB need to be sent on every paid claim or only for those claims that have a member liability attached?

A: Full EOB requirements can be found in the Operations Manual, Chapter 8, Section 8. EOBs need to be sent for every claim paid or denied except where specifically waived per the above reference, such as where there is no patient liability. Please note that since enrollment is not required, there are no "members" in a literal sense.

#19. Q: Will the contractor be responsible for the standard per claim fees charged by Medicare Intermediaries and Carriers for the EDI receipt of Medicare Crossover claims or does Tricare have a direct arrangement for the receipt of Medicare Crossover claims?

A: The Medicare crossover fees are paid to Medicare contractors by the TDEFIC contractor (See the Operations Manual, Chapter 22, Section 4, paragraph 7.0). These fees cover the transmission of data on paid claims from the Medicare contractor to the TDEFIC contractor in order to facilitate processing as second payer on the TDEFIC claims. The contractor is to submit non-TED vouchers (see Chapter 3, Section 4) covering these expenses to TMA on an as needed basis, generally once or twice a month.

#20. Q: Understanding that the contractor will be dependent on DEERS for determining TRICARE for Life eligibility, please confirm that the government will be ready for the contractor to begin testing with new DEERS not later than 30 days from the start of the first transition period beginning 6/1/03. We believe this will be a critical part of the benchmark test and will need to be thoroughly tested by the government and contractor prior to the first benchmark in November 2003.

A: We have been assured that new DEERS will in fact be ready. We encourage you to attend the Information Technology session to be held in Aurora on October 2nd if you wish to expand upon your DEERS questions.

#21. Q: What is the government's timetable for having TEDS available to contractors for testing so that the contractor can complete their full internal testing prior to the official benchmark test? Since the first benchmark for Region 11 would need to be November 2003, we are assuming that TEDS testing would begin a minimum of 60 days prior to that and not later than August 2003.

A: Your assumption is reasonable. A final timeline for testing will be established collaboratively with the successful offeror in the post-award transition meetings.

#22 Q: Is the government planning to add the dual eligible members under 65 and dependents of active duty members eligible for Medicare to the eligibility files provided for TRICARE for Life so the contractor will be able to add these people to the crossover files?

A: Yes. This expansion of the data match will take place prior to the beginning of TDEFIC claims processing.

#23 Q: In the your response to your Question #9, you state the "Provider Affiliation Code" on the central provider record can determine the provider's network status. Today this code merely reports if a provider has ever been a TRICARE network provider. This code has no dates associated with it that could be read by the contractor to determine if a provider has network status for the particular dates of service on the claim they are processing. Does the government intend to add date information to this code on their file to make this information useful to the TDEFIC contractor prior to start of health care delivery?

A: There are no plans to add effective dates to this data element. In the event the successful offeror believes they need additional information to adjudicate the claim and assess cost shares properly, they can secure the provider's current network status from the incumbent MCS contractor. This could be done on an individual basis or as addressed in the alternative approach described in the response cited; i.e., by negotiating agreements with the MCS contractors to receive a simplified copy of their provider file showing provider network status.